Health, Social Care and Sport Committee
Inquiry into loneliness and isolation

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The Centre for Ageing and Dementia Research (CADR) and Centre for Innovative Ageing (CIA) is pleased to feed into the committee's inquiry into loneliness and social isolation in later life. The comments below will focus on prevalence, and risk factors associated with loneliness and social isolation in later life, reflecting the expertise and strengths within the Centres.

Introduction

1. Loneliness and Social isolation are distinct but related concepts. Loneliness can be defined as "the unpleasant experience that occurs when a person's network of social relations is deficient in some important way, either quantitatively or qualitatively"[1] In contrast, social isolation is an objective measurement, based on the absence of contact with other people, which can be quantified, and integration with other members of society. It is the opposite of good social support.[2] Individuals with a small number of meaningful ties or who have no social network are, by definition, socially isolated. People who have a small number of social ties are at greater risk of becoming lonely. However, older people can be lonely but not isolated, or isolated and not lonely, or both isolated and lonely or neither.[2]

Evidence for the scale and causes

2. Data from the Cognitive Function and Ageing study -Wales (CFAS-Wales) found that 25.3% of older adults in Wales reported being lonely and 26.9% socially isolated.[1]
3. The causes of loneliness and social isolation are multifactorial and complex. Pathways into loneliness and social isolation may be the result of single life event i.e. bereavement or may result from cumulative events or losses over time.[1,3]
4. Our research has identified a range of factors which increase vulnerability to loneliness and social isolation. These include; living in a rural area, bereavement, marital status (being single, divorced or widowed), advanced age, living alone, retirement, financial resources, admission to a care home, disability, sensory impairments, being a carer or giving up caring, being in poor health, functional impairments, cognitive impairment, living more than 50 miles from family and having low levels of participation in religious or community groups.[1,3-5]
5. Although there are similarities in the risk factors associated with loneliness and social isolation later life, interim results from CFAS Wales identified key differences in the risk factors associated with the four categories of loneliness and social isolation. Risk factors

predicting being lonely but not isolated included depression, poor health, and low self-esteem. Predictors of being isolated but not lonely included having a low level of education, advanced age (85years and over) being male, childless, depression, poor health, and low levels of interpersonal control (the individual's ability to interact with others). The predicators of being both lonely and isolated included advanced age (85years and over) being male, divorced or separated, childless, depression, poor health low self-esteem and low levels of interpersonal control.[3]

6. For older people receiving formal care services in Wales: our research found that extracare environments provided the conditions for increased social interaction and this was particularly effective for older widows. However, there was no difference in the levels of loneliness between three living environments (community, residential care and extracare sheltered housing). Analysis of qualitative data illustrated the point that although social interactions were increased in extracare environments the exchanges did not necessarily lead to high quality and emotionally satisfying social relationships. Social interactions appeared to be fairly superficial in nature, and consisted of encounters in the communal living areas in the facilities rather than in the private confines of the residents' flats.[6]
7. Qualitative research we have conducted with older lonely adults in Wales, as part of the CFAS-Wales study has identified precursors which increase vulnerability to loneliness and social isolation with age. These include personality traits such as shyness, or introversion which may inhibit the development of social networks across the individual life course.[5] Our research indicates that these personality traits may also act as a barrier, preventing older people engaging in group activities aimed at alleviating loneliness and social isolation.
8. Financial constraints in later life have been found to increase vulnerability to loneliness and social isolation in later life. Research undertaken in Canada found loneliness was higher among long term residents in newly affluent rural communities. Financial constraints prevent older adults participating in activities and organizations, which result in reduced social connections, increasing vulnerability to loneliness.[7] This finding is supported by our qualitative research conducted as part of CFAS Wales, which found that limited financial means constrained some older adults from accessing support services which would help alleviate their loneliness.[3]
9. Our research indicates that driving cessation can also be a casual factor in some people becoming lonely and or isolated in later life.[3]

Impact of loneliness and isolation on older people

10. Our research demonstrates the impact of loneliness and social isolation on the physical and mental wellbeing of older adults in Wales. Preliminary analysis using interim data from the CFAS Wales study, found a statistically significant association between loneliness and depression, with 59.1 % older participants who reported being sad or depressed all or most of the time were also lonely[3]. The research evidence shows that depressive symptoms have a significant impact on loneliness, whereby greater levels of depressive symptoms increase levels of loneliness.[7] Depression was also found to be predictive of being 'lonely not isolated' and 'lonely and isolated'. These findings were supported in the qualitative study with some lonely and isolated older adults referring to it as being in a 'very dark place.' [7]

11. Our research in Ireland suggests that depression is a 'cognitive process' that moderates how intensely people react to their personal levels of social contact and support, and their functional ability to participate fully in society. Adjusting one's expectations regarding quantity and quality of social contact - *desired* social relations - in light of one's physical ability to maintain social ties is more difficult to achieve for those with depression.[4]
12. There is evidence to suggest that some older adults use alcohol as a mechanism to cope with loneliness. Findings from our qualitative study show that some older adults use alcohol as a way of alleviating the negative emotions associated with being lonely and /or isolated. While others spoke about their fear of turning to alcohol in order to cope with loneliness.[3]
13. Regardless of the pathway into loneliness and social isolation, we found that the onset of loneliness and social isolation represented a significant threat to the individual's identity. The evidence shows that loneliness and social isolation disrupt an older person's sense of self, challenging notions of who they are, their social roles, personality and interests, as well as challenging the assumptions they hold about their relationships with others. This can have implications for their loneliness trajectory. [3]
14. Disabled older adults are disproportionately affected by loneliness and social isolation in later life. We found that greater disability is associated with greater levels of loneliness.[1,4] This is supported in the qualitative work undertaken as part of CFAS Wales which found that older participants with physical or sensory impairments were chronically lonely.[3]
15. Older adults with cognitive impairments are disproportionately affected by loneliness and social isolation. The research evidence shows that people with severe cognitive impairment have fewer social contacts than those with moderate or no cognitive impairment. The greater the severity of cognitive impairment the greater the loneliness. We argue that the ways in which society interacts and treats older people can shape their social relationships, which can result in them being excluded from contact with family, friends and neighbours. Ageing stereotypes and society's expectations regarding older people can also influence and shape how an older person with cognitive impairment perceives themselves.[1]
16. Interim data from CFAS Wales identified a socio economic gradient in loneliness. Older adults living in local authority housing and those with lower educational attainment were found to be at greater risk of loneliness as they aged.[3.]
17. Research undertaken in Birmingham with minority elders aged 65+ found very high prevalence of loneliness (between 24 and 50%) among older adults from China, Africa, Pakistan, Bangladesh and the Caribbean. Prevalence of loneliness among older adults from India was similar to that found in older adults across the UK.[8]
18. Research in South Asia, and in England and Wales with migrants from collectivist cultures found that all of the groups studied hold certain expectations concerning the role of the family. On the whole, the *Multigenerational: Younger Family* networks appear to be the desired network type in collectivist cultures. These networks are family focused networks and demonstrate normative differences in networks between collectivist and individualistic cultures. Locally integrated or diverse networks that have a high salience of contact with friends, family and involvement in community (and bear some similarities to the Multigenerational: Older Integrated or Middle Aged Friends networks) are more robust in individualistic cultures and less prone to loneliness and other negative wellbeing outcomes. This, however, is not the case in collectivist cultures. Contrary to individualistic cultures we

found that the most robust networks are privatized family focused networks that include few non-kin members, that is those that we called *Multigenerational: Younger Family* networks. Deviation in network configuration resulted in worse well-being outcomes for older migrants, in terms of worse quality of life (with the exception of Middle Aged Friends) and greater loneliness. Thus, the cultural normative expectations about sources of support and family forms have a bearing on the extent to which networks can protect or buffer an older person from adverse outcomes.[9,10]

The impact of loneliness and isolation on the use of public services in Wales.

19. There is a significant gap in the research evidence in Wales on the impact of loneliness and social isolation on the use of public services. Research evidence is needed to ascertain the extent of healthcare utilisation and service usage among lonely and/or isolated older adults in Wales.

Ways of addressing problems of loneliness and isolation in older people,

20. Interventions that focus on increasing social contact may be valuable for people with few family or friends or those who have experienced a reduction in their social network. However, our research demonstrates the complex interplay of factors which contribute to loneliness and social isolation in later life. The effectiveness of interventions is therefore dependent on our understanding and addressing the complexity of loneliness and social isolation, the needs of different groups of older people and the barriers which prevent people overcoming loneliness and social isolation. Our research indicates that individualised responses to loneliness and social isolation interventions may be required.

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